MONTANA
Department of Public Health & Human Services

Well Child EPSDT

Early and Periodic Screening, Diagnosis and Treatment is the federally sponsored, comprehensive health care benefits package for Medicaid-enrolled children through age 20. It helps families get early identification and treatment of medical, dental, vision, mental health and developmental problems for their children. All Medicaid families are encouraged to use these services.

EPSDT includes a medical screen (sometimes called a well child check-up), vision screen, dental screen and hearing screen for all Medicaid-enrolled children. There are four periodicity schedules, one each for well child screens, dental screens, vision screens, and hearing screens. These periodicity schedules are shown in Appendix B. These screens help spot and take care of health problems early in a child's growth. Each screen includes a detailed health and developmental history; a comprehensive, unclothed physical exam; age-appropriate immunizations and laboratory tests; and health education. The screens are provided at specific periods throughout a child's growth. See *Appendix B: Well Child Screen Chart* for specific recommendations for each age.

When a Medicaid-eligible child requires medically necessary services, those services may be covered under Medicaid even if they are not covered for adults. Health care, diagnostic services, treatments and other measures that would correct or improve defects or physical or mental illnesses or conditions are available based on medical necessity. If these services are not a "covered service" of Montana Medicaid, prior authorization is required. For more information on prior authorization, see the *Key Contacts* chapter of this manual.

The Well Child Screen

The foundation of Well Child EPSDT is the Well Child Screen. These screens should begin as early as possible in a child's life or as soon as the child is enrolled in Medicaid. The Well Child EPSDT program's Well Child Screens are based on a periodicity schedule established by medical, dental and other health care experts, including the American Academy of Pediatrics. The *Well Child Screen Recommendations* chart in *Appendix B* is designed for providers to copy and maintain for their records.

Montana Medicaid has initiated a project to improve provider awareness of the EPSDT program and the comprehensiveness of the well child screen. Beginning January 2006 an enhanced fee will be added to the reimbursement for well child screens. The Department will be conducting audits of medical records to ensure that the screens provided meet the expectations defined in this chapter.

Every infant should have a newborn evaluation after birth. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time. If a Well Child Screen shows that a child is "at risk" based on the child's environment, history, or test results, the provider should perform required or recommended tests even though they may not be indicated for the child's age. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

A. Initial/interval history

A comprehensive history, obtained from the parent or other responsible adult who is familiar with the child's history, should be done during the initial visit. Once it is done, it only needs to be updated at subsequent visits. The history should include the following:

- Developmental history to determine whether the child's individual developmental processes fall within a normal range of achievement compared to other children of his or her age and cultural background.
    - Discuss the child's development, as well as techniques to enhance the child's development, with the parents.
- Nutritional history and status. Questions about dietary practices indentify unusual eating habits, such as pica or extended use of bottle feedings, or diets which are deficient or excessive in one or more nutrients.
- Complete dental history.

B. Assessments

- ***Appropriate developmental screening.*** Providers should administer an age-appropriate developmental screen during each Well Child Screen. Results should be considered in combination with other information gained through the history, physical examination, observation, and reports of behavior. If developmental problems are identified, appropriate follow-up and/or referral to proper resources should be made.

  Speech and language screens identify delays in development. The most important readiness period for speech is 9 to 24 months. Parents should be urged to talk to their children early and frequently. Refer the child for speech and language evaluation as indicated.

  Parents of children with developmental disabilities should be encouraged to contact Parents Let's Unite for Kids (PLUK). PLUK is an organization designed to provide support, training, and assistance to children with disabilities and their parents. Visit the web site (see *Key Contacts*), or call or write:

PLUK
516 N. 32nd St.
Billings, MT 59101
(406) 255-0540 Phone
(800) 222-7585
(406) 255-0523 Fax

- ***Nutritional Screen.*** Providers should assess the nutritional status at each Well Child Screen. Children with nutritional problems may be referred to a licensed nutritionist or dietician for further assessment or counseling.
- ***Risk Assessment Screen.***
  - **Emotional.** Signs and symptoms of emotional disturbances represent deviations from or limitation in healthy development. These problems usually will not warrant a psychiatric referral but can be handled by the provider. He or she should discuss problems with parents and give advice. If a psychiatric referral is warranted, the provider should refer to an appropriate provider.
  - **Risky behaviors.** The provider should screen for risky behaviors (substance abuse, unprotected sexual activity, tobacco use, firearm possession, etc.). In most instances, indications of such behavior will not warrant a referral but can be handled by the provider. He or she should discuss the problems with the client and the parents and give advice. If a referral is warranted, the provider should refer to an appropriate provider.
  - **Blood lead.** Medicaid children should be **tested** for lead poisoning at 12 and 24 months of age. Children up to age 6 who have not been checked for lead poisoning before should also be tested. **All** children in Medicaid are at risk of lead poisoning. To ensure good health for the child, the federal government **requires** that all Medicaid children be tested. All Medicaid children at other ages should be screened.

    Complete a verbal risk assessment for all Medicaid children to age 6 at each EPSDT screening:
    - Does your child live in Butte, Walkerville or East Helena, which are designated high-risk areas?
    - Does your child live near a lead smelter, battery recycling plant, or other industry (operating or closed) likely to release lead?
    - Does your child live in or regularly visit a house built before 1960, which may contain lead paint?
    - Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?
    - Does your child live in a home where the plumbing consists of lead pipes or copper with lead solder joints?

Providers must use their medical judgment in determining applicability of performing specific test.

A blood lead level test should be performed on all children at 12 and 24 months of age.

- Does your child frequently come in contact with an adult who works with lead, such as construction, welding, pottery, reloading ammunition (making own bullets), etc.?
- Is the child given any home or folk remedies? If yes, discuss.

If the answers to all questions are negative, a child is considered at low risk for high doses of lead exposure. Children at **low risk** for lead exposure must receive a **blood test at 12 and 24 months.** If the answer to any question is positive, a child is considered at **high risk** for high doses of lead exposure and **a blood lead level test must be obtained immediately** regardless of the child's age.

- **Tuberculin.** Tuberculin testing should be done on individuals in high-risk populations or if historical findings, physical examination or other risk factors so indicate. High-risk populations include Asian refugees, Native American children, and migrant children.

C. Unclothed physical inspection

At each visit, a complete physical examination is essential. Infants should be totally unclothed and older children undressed and suitably draped.

D. Vision screen

A vision screen appropriate to the age of the child should be conducted at each Well Child Screen. If the child is uncooperative, rescreen within six months.

E. Hearing screens

A hearing screen appropriate to the age of the child should be conducted at each Well Child Screen. All newborns should be screened.

F. Laboratory tests

Providers who conduct Well Child Screens must use their medical judgment in determining applicability of performing specific laboratory tests. Appropriate tests should be performed on children determined "at risk" through screening and assessment.

- ***Hematocrit and hemoglobin.*** Hematocrit or hemoglobin tests should be done for "at risk" (premature and low birth weight) infants at ages newborn and 2 months. For children who are not at risk, follow the recommended schedule.
- ***Blood lead level.*** **All** children enrolled in Medicaid are at risk of lead poisoning. To ensure good health for the child, the federal government requires that all Medicaid children ages 12 and 24 months of age, or up to 72 months if not previously tested, should have a blood lead level test unless medically contraindicated. If an elevated blood level is discovered, a child should be retested every three to four months until lead levels are within normal limits, and then annually through 6 years of age. See page 3.3 for more details.

- ***Tuberculin screening.*** Tuberculin testing should be done on individuals in high-risk populations or if historical findings, physical examination or other risk factors so indicate. See page 3.4 for more details.
- ***Urinalysis.***
  - Because of heightened incidence of bacteriuria in girls, testing may be appropriate.
  - Children who have had previous urinary tract infections should be rescreened more frequently.
  - If test results are positive but the history and physical examination are negative, the child should be tested again in two weeks.
- ***STD screening.*** All sexually active clients should be screened for sexually transmitted diseases (STDs).
- ***Pelvic exam.*** All sexually active females, and all females 18 and over regardless of sexual activity, should have a pelvic exam. A pelvic exam and routine pap smear should be offered as part of preventive health maintenance.

G. Immunizations

- The immunization status of each child should be reviewed at each Well Child Screen. This includes interviewing parents or caretakers, reviewing immunization records, and reviewing risk factors.
- A checklist for a child's immunization regimen is provided in the W*ell Child Screen Recommendations* chart (*Appendix B*) for your convenience. The *Recommended Childhood Immunization* schedule is available on the *Provider Information web site* (see *Key Contacts*) and the *Centers for Disease Control and Prevention (CDC)* web site (see *Key Contacts*). This schedule is approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). The schedule on the website is updated as recommendations from the ACIP are received.
- If a child was not immunized at the recommended time, use the *Recommended Childhood Immunization* schedule to bring the child's immunizations current.

H. Dental screen

The child's dentist should perform annual dental screens, and results should be included in the child's initial/interval history. Other providers should perform an oral inspection, fluoride varnish (as available) and make a referral to a dentist for any of the following reasons:

- When the first tooth erupts and every six months thereafter.
- If a child with a first tooth has not obtained a complete dental examination by a dentist in the past 12 months.
- If an oral inspection reveals cavities, infection, or the child is developing a handicapping malocclusion or significant abnormality.

I. Discussion and counseling/Anticipatory guidance

Providers should discuss examination results, address assessed risks, and answer any questions in accordance with the parents' level of understanding. Age-appropriate discussion and counseling should be an integral part of each visit. Please allow sufficient time for unhurried discussions.

At each screening visit, provide age-appropriate anticipatory guidance concerning such topics as the following:

- Auto safety: Car seats, seat belts, air bags, positioning young or lightweight children in the backseat.
- Recreational safety: Helmets and protective padding, playground equipment.
- Home hazards: Poisons, accidental drownings, weapons, matches and lighters, staying at home alone, and use of detectors for smoke, radon gas, and carbon monoxide.
- Exposure to sun and secondhand smoke.
- Adequate sleep, exercise and nutrition, including eating habits and disorders.
- Peer pressure.
- General health: Immunizations, patterns of respiratory infections, skin eruptions, care of teeth.
- Problems such as stealing, setting fires, whining, etc. (as indicated by parental concern).
- Behavior and development: Sleep patterns, temper, attempts at independence (normal and unpleasant behavior), curiosity, speech and language, sex education and development, sexual activities, attention span, toilet training, alcohol and tobacco use, substance abuse.
- Interpersonal relations: Attitude of father; attitude of mother; place of child in family; jealousy; selfishness, sharing, taking turns; fear of strangers; discipline—obedience; manners—courtesy; peer companionship/relations; attention getting; preschool, kindergarten and school readiness and performance; use of money; assumption of responsibility; need for affection and praise; competitive athletics.

Appendix B: Well Child Screen Chart

Rev 09/05

Well Child Screen Recommendations

Child's Name_____ Child's SSN_____ Child's Date of Birth _____

Parent's Name_____ Parent's SSN_____

	Well Child Screen component	Age requirements	Date completed
A.	**Initial/Interval History**		
	Developmental history	all ages	
	Nutritional history	all ages	
	Complete dental history	all ages	
B.	**Assessments**		
	Appropriate developmental screen		
	motor	all ages	
	social	all ages	
	cognitive	all ages	
	speech	all ages	
	Nutritional Screen	all ages	
	Age Appropriate Risk Assessment Screen		
	Emotional	all ages	
	Risky behaviors	all ages	
	Blood Lead	all ages	
	TB	all ages	
C.	**Unclothed Physical Inspection**		
	Height/weight	all ages	
	Head circumference	newborn through 2 years old	
	Standard body systems	all ages	
	Check for signs of abuse	all ages	
	Blood pressure	3 years on	
D.	**Vision Screen**		
	External inspection for gross abnormalities or obvious strabismus	all ages	
	Gross visual acuity with fixation test	birth to 2 years	
	Light sensation with papillary light reflex test	birth to 2 years	
	Observation and report of parent	birth to 2 years	
	Examination of red reflex	all ages	
	Alternate cover test	2 years to 5 years	
	Corneal light reflex	2 years to 5 years	
	Visual acuity using the Illiterate Snellen E chart (or similar)	4 years and over	
	Color discrimination on all boys (once)	5 years and over	
E.	**Hearing Screen**		
	History, physical and developmental assessment	all ages	
	Middle ear exam by otoscopy	all ages	
	Administration of high risk criteria	6 months OR 2 years	
	Assess hearing capability	6 months OR 2 years	
	Administration of puretone audiometry	5 years and over	
F.	**Laboratory Tests (use medical judgment and risk assessment to determine need EXCEPT for blood lead)**		
	Hematocrit or hemoglobin	9-15 months if indicated by risk assessment	
	Urinalysis	if indicated by risk assessment	
	Tuberculin	if indicated by risk assessment	

	Cholesterol	if indicated by risk assessment and age appropriate (8 - 14)	
	Hereditary/metabolic screening (e.g., thyroid, hemoglobinopathies, PKU, galactosemia)	newborn	
	Blood lead	12 and 24 months and other ages if at risk	
	STD screening	sexually active adolescents	
	Pap smear	sexually active adolescents	
	Other tests as needed		
G.	**Immunizations (the immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP); if the committee has released an updated schedule, that schedule supercedes this one)**		
	Hepatitis B (Hep B)	1 at birth, 2nd by 4 months, 3rd between 6-18 months, and "catch up" at any tiem	
	Diphtheria, tetanus, pertussis (DTaP)	2 mos, 4 mos, 6 mos, 15-18 mos, 4-6 years	
	H. influenza type b (Hib)	2 mos, 4 mos, 6 mos, 12-15 mos	
	Inactivated polio (IPV)	2 mos, 4 mos, 6-18 mos, 4-6 years	
	Pneumococcal conjugate (PCV)	2 mos, 4 mos, 6 mos, 12-15 mos	
	Measles, mumps, rubella (MMR)	12-15 mos, 4-6 years, "catch up" any time	
	Varicella (Var) (if given after 12 years, 2 doses separated by 1 month should be given)	12-18 mos, "catch up" any time	
	Tetanus (Td)	11-12 years, then every 10 years	
H.	**Dental Screen (to be done by medical health provider)**		
	Counseling on oral hygiene	all ages	
	Counseling for non-nutritive habits (thumb-sucking, etc.)	through age 6 years	
	Initial/interval dental history	all ages	
	Oral inspection of mouth, teeth, gums	all ages	
I.	**Discussion and Counseling/Anticipatory Guidance**		
	Address needs and topics appropriate for age level per risk assessment	all ages	